

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034206

FILED VS. SEP 28 1960

Registration District No. 75 Primary Registration District No. 3016 Registrar's No. 140

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clinton</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Cameron</b>		Length of stay in 1b <b>8 days</b>		c. CITY OR TOWN <b>Cameron</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Comm. Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>915 W. 4th. St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>WEIR</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-10-1890</b>	
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Louisville, Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>William Weir</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Shanks</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Alice Weir</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW.1 WW.1</b>				16. SOCIAL SECURITY NO. <b>R.R. Retirement</b>		17. INFORMANT <b>Mary Alice Weir, Cameron, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic myocardial infarction</b> DUE TO (c) <b>arteriosclerotic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>Dec 22, 1955</b> to <b>Sept 19, 1960</b> and last saw him alive on <b>Sept 19, 1960</b> . Death occurred at <b>12:30 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>J. A. Kuehn</b> (Degree or title)				22b. ADDRESS <b>M.D. Cameron, Mo.</b>		22c. DATE SIGNED <b>9-21-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-21-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic</b>		23d. LOCATION (City, town, or county) (State) <b>Cameron, Mo.</b>	
24. FUNERAL DIRECTOR <b>Poland Funeral Home, Cameron, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Sept 26 - 1960</b>		26. REGISTRAR'S SIGNATURE <b>Francis D Crawford</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 7 1963

VS APR 19 1961

OCT 4 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Cameron

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.